Children's Mental Health Waiver
Exceptional Service Plan Request

This form must be completed for all Service Plans that exceed $7,000 total quarterly costs or if Child Training units exceed 96 units per quarter.

Name of Youth: _____

Service Plan Date: _____

Total Service Plan Amount = $ _____ $ Amount > $7,000 quarterly costs $ _____

Total Service Plan Amount for Last Approved Service Plan (if applicable) = $ _____

Exceptional services are identified for:

☐ Waiver Services

- ☐ Family Care Coordination — Units requested: _____
- ☐ Family Training and Support — Units requested: _____
- ☐ Individualized Child Training and Support — Units requested: _____

☐ Medicaid Covered Mental Health Services

- Service: _____ Units requested: _____
- Service: _____ Units requested: _____

☐ Other Medicaid State Plan Services

- Service: _____ Units requested: _____
- Service: _____ Units requested: _____

Explanation of Team's rationale for exceptional service request
Provide detailed explanation of Team's rationale for request; what options were considered in the decision; and what other community, natural, and non-waiver supports were tried before this request was made.

Anticipated time period for Exceptional Service request is:

- ☐ Short term request for this plan period
- ☐ Long term request for multiple plan periods or length of stay on waiver

Explain:

Service Plan Focus to Best Utilize Exceptional Service Needs
Outline plan priorities and focus of outcome objectives and behavioral support to demonstrate exceptional service need.

Service Plan Monitoring to Evaluate Exceptional Services
A summary of this monitoring will be included in all Service Plan review reports submitted by the Family Care Coordinator.

Monitoring Focus/Criteria: _____

Responsible Person: _____

Schedule: _____

Mechanism Used: _____
(data review/reporting, in-person contact/follow-up, scheduled meeting w/service provider, etc.)

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Schedule: _____

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(data review/reporting, in-person contact/follow-up, scheduled meeting w/service provider, etc.)

Additional Information:

Family Care Coordinator: _____ Date: _____

Approved by MHD_____ Date: _____